Out-of-hours care: do we?

The national GP Patient Survey (GPPS), the largest routine survey of primary care patients to be conducted anywhere in the world, has recently provided insights into patients' experiences of out-of-hours patient care in England. 'Out-of-hours' refers to that period between 6.30 p.m. and 8 a.m. weekdays, at weekends, and on bank holidays and public holidays.[1]

Routine data have, until now, been reported for each of England's 8278 practices, 152 primary care trusts (PCTs), and 10 strategic health authorities. GPPS data that were reported recently for each of the 100 out-of-hours organisations currently providing care in England,[2] document the patchy nature of the provision, although around two-thirds of responders reported their experience was at least 'good'. A similar proportion of survey respondents reported that they would know how to contact an out-of-hours GP service, the remaining third reported they would not know how to do this. Many of those in London figure prominently at the lower end of the rankings, but whether this is because of the quality and timeliness of the service or because of the challenges of providing out-of-hours care to some populations is unclear.

It is perhaps not surprising to discover that 60 patients in Wales, interviewed as part of a qualitative study of GP out-of-hours service users[3] reported in this issue of the *BJGP*, also reported variations in their experiences of care. The authors call for out-of-hours triage services that are flexible and streamlined. In particular, they note the adverse effect on reported experience when delays and obstacles, such as the nature and duration of questioning and the repetition of administrative information, appeared to block access to the sometimes-elusive goal of a consultation with a doctor. In the GPPS, around a third of recent service users reported that they thought it took 'too long' to receive care from the out-of-hours GP service.

Twenty years ago a common mantra often quoted by GPs in reassuring patients was: 'We have responsibility for your care 24 hours a day, 365 days a year'. Today, GPs have forfeited the moral high ground underpinned by that statement, and with it, lost much of the moral authority of the position. 'Others' now provide care for our patients for 70% of the time.

But now, patients are faced with choice — perhaps too much choice — in respect of healthcare needs that emerge out of hours. Choice of location, choice of mode of contact, choice of health professional may sound good. But such choice is expensive to provide, and although perhaps desirable, may lead to confusion for users at a vulnerable time. Certainly, that is what some users have recently reported.[3,4] Patients are not merely 'casual' users of out-of-hours services. For many, the decision to seek care out of hours is made with forethought, perhaps after consulting others, and cognisant of the needs of the health professionals potentially providing care (such as the need for sleep and a reluctance to disturb a heath professional at night unnecessarily).[4]

GPs have faced a substantial and sustained increase in out-of-hours workload over many years.[5] Society's 24-hour expectations for many services, including health care, seemed fuelled by government policy on access. Gone are the days of encouraging contact first with the practice for out-of-hours care — a situation which could be monitored by GPs and, in line with Stott and Davis' influential model,[6] potentially modified in line with the gatekeeper role of the British GP. In came the days of unfettered access, a free-for-all, come-when-you-like policy which has resulted in a burgeoning of services: NHS Direct, walk-in centres, GP-led health centres, independent and NHS-based out-of-hours providers, accident and emergency (A&E) departments, and 24-hour pharmacies. What are the health economic consequences of a one-third increase[7] in the number of non-traumatic night-time attendances at A&E departments occurring at the same time as GPs opted out of out-of-hours care?

And while the case of Dr Ubani, currently being considered by the Care Quality Commission (CQC),[8] raises important issues of patient safety and the governance of out-of-hours providers and commissioners, the danger of over-reaction — dealing with the big case but missing the big picture — is all too evident. The recent CQC interim findings into the independent provider for whom Dr Ubani worked made clear the CQC's view about the need to dig deeper to examine: 'the finer detail of the actual care patients receive, to ensure the service is safe and meeting people's needs'.

What patients want is good access to reliable, authoritative, and reassuring medical advice, and with that, the potential for their needs to be addressed in a way which is most appropriate to their circumstances at the time, whether through telephone advice, face-to-face consultation, or a home visit. There is more than adequate evidence (confirmed by the results of the GPPS) that patients see good care as rapidly accessed care.

The benchmark run by the Primary Care Foundation[9] highlights the wide variation between services. It also demonstrates that it does not have to be like this. Services with very different operational models, ranging from those delivering over 70% telephone advice (and less than 3% home visits) to others with less than 40% advice (and over 15% home visits), are among the better group on various measures of patient experience adopted by the Foundation. The common factor unifying these 'better' models of care is not the structure of the care but their speed of response, with over 70% of cases of all levels of priority being definitively accessed in less than 20 minutes.

The truth is we can't afford the present situation. The £6000 it cost individual GPs to relinquish the 24-hour responsibility in 2004[1] was met in the first year at a cost to the nation for re-providing the service of £13 000 per GP: in excess of a third of a billion pounds (2004 prices).[1] Against national standards, current care is 'good' for the majority of patients.[10] In a season of raised political expectations,[11] great care should be given to the step-change cost and structural implications of delivering care which is judged 'excellent' by the majority of patients.[10]

What is the answer to the present confusing, costly, and sometimes chaotic situation prevailing in out-of-hours care? The Minister of State for Health Services, Mike O'Brien, very recently suggested that out of hours care: 'clearly needs further reform' and that 'Regulation, in particular, needs much more central drive'.[12] Healthcare designers, managers, and politicians need to capture the vision — not all healthcare needs arising out-of-hours need attention out-of-hours. Where those needs are presented, they must be managed in a way that is effective, cost-effective, and of the highest quality. Patients need to use the service wisely; informal sources of care may well be an effective and safe means of obtaining reassurance. The availability of such sources of care presents a substantial and increasing challenge in a mobile society where a substantial (17%) and increasing proportion of people live alone,[13] and where carers of the highest users of out-of-hours care — children[14] — may themselves be isolated from readily available informal medical advice.

Whatever the regulation or commissioning structure, GPs have a vital role. GPs need to bring the energy, skill, commitment, and professionalism that has characterised our approach to delivering a high-quality in-hours service[15] to bear on the development and delivery of quality out-of-hours services fit for the 21st century. Such services will be characterised by being led by GPs through their involvement in overseeing the delivery of care. The primacy of patient and family needs to be at the heart of any redesigned care. Some sense of personal responsibility must be re-discovered on both sides of the out-of-hours care equation; and embedding the service in the personal relationship which still exists between many patients and 'their' GP is likely to offer great potential rewards in cost, patient experience of care, and clinical outcomes.

GPs may hold the service to account by asking for information about the provider's performance, perhaps using the data from the GPPS as a springboard for that review. Typically, about 1000 will provide their views about the out-of-hours service in each PCT in England. Ask where your service is in the pecking order. Where care might be judged to be less than adequate for individual patients, ask the provider to investigate formally any such instances, not necessarily with a view to punitive responses (at least in the first instance), but with an eye on critical service review and the learning opportunities such an approach might provide.

Health professionals also need to be alert to the training issues presented by the present situation. There is concern that GPs in training, having only limited opportunity for exposure to the challenging environment of out-of-hours care, may be at risk of not acquiring the essential ability to undertake rapid high-quality clinical assessment in sub-optimal physical settings which may be clinically isolated.

None of these approaches necessarily involves GPs in direct provision of out-of-hours care. But for some GPs, countenancing a return to front-line provision of care, perhaps working within some form of locally managed arrangement which reinforces a sense of personal care for both patient and doctor, may not be impossible. At a minimum, research into the acceptability, feasibility, utility, and potential of re-engaging GPs in out-of-hours care is necessary and important.

A recent joint report of the Department of Health and the Royal College of General Practitioners[16] has made specific recommendations regarding three areas of out-of-hours care: commissioning and performance management of services; selection, induction, training and use of clinicians; and the management and operation of medical performers lists. The report and proposals are to be welcomed in highlighting key structural and governance issues relating to out-of-hours care. But most of the recommendations are aspirational. For example, the authors note their surprise that 5 years after the introduction of national quality requirements, some services were still not achieving compliance. However, the recommendation that PCTs and providers 'should' review their arrangements for receiving reports on patient experience is just too weak: providers must now adopt clear processes for monitoring such experience using high-quality, validated, and reliable instruments to gather information which will usefully guide and inform service development. There needs to be a clear expectation that failure to deliver these and other national requirements will result in review of provider arrangements.

Founder of the Harvard-based Institute for Healthcare Improvement, Don Berwick, has recently identified NHS general practice as the 'soul of a proper, community-oriented, health-preserving care system'.[17] A new partnership is needed for out-of-hours care, one which recaptures the ethos and values of general practice and accommodates the legitimate aspirations of patients, and the skills of evidence-based, informed, health-service management.

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Near-patient testing in primary care

In the current climate of streamlined health care with an emphasis on community-based care and one stop clinics, the concept of near-patient testing is appealing. Near-patient testing (also known as point-of-care testing) is defined as an investigation taken at the time of the consultation with instant availability of results to make immediate and informed decisions about patient care, and has gained much attention over the last 15 years.

Near-patient testing offers a number of potential advantages in primary care, including earlier diagnosis, communication of diagnosis, and disease management, with potential for improved outcomes, improved patient satisfaction, and cost-effectiveness. Other potential advantages include reducing health inequalities by being accessible to certain hard to reach socioeconomic or ethnic groups. Use of simple urine testing strips and blood glucose measurements are routine in primary care, although more sophisticated near-patient tests have been limited to anticoagulant monitoring, diabetes management, and testing for C-reactive protein and *Helicobacter pylori*.

A study in this issue of the *BJGP* by Laurence *et al* evaluated patient satisfaction in relation to near-patient testing in a large randomised controlled trial (RCT) in Australia.[1] Four key results are highlighted in this study: patients felt that near-patient testing allowed discussion of the management of their condition with their GP; patients felt they were more motivated to look after their condition; patients preferred near-patient testing using finger prick tests; and they were more satisfied, in particular, those who had anticoagulant monitoring.

There have been only a few RCTs of patient satisfaction with near-patient testing and these have reported mixed findings. For example, one RCT showed that people with diabetes accepted near-patients tests and confirmed that they may have potential benefits, such as saving time, reducing anxiety, and both patient management and job satisfaction.[2,3] However, satisfaction with diabetes care was already high in both intervention and control groups and the trial failed to show any improvements in outcomes for these patients; in addition, there were no cost savings.[3] There is support among healthcare professionals for the principles of near-patient testing,[3,4] although at the same time healthcare practitioners have concerns about time pressures, maintenance, quality control, and cost implications.[4]

In the UK there has been recent interest in lipid monitors which have increased in availability over the years with the potential to assess cardiovascular risk.[5] These machines have been validated for bias and imprecision and have been shown to have overall analytical goals for near-patient testing that are equivalent to those used in laboratories.[5] One area where these monitors are being seriously considered in the UK is to help implementation of the ambitious NHS Health Check programme,[6] in particular in the community pharmacy setting.

Previous studies have evaluated the feasibility of oral anticoagulant therapy monitoring using near-patient testing by community pharmacists, and have shown promising results.[7] Furthermore, a recent evaluation of a cardiovascular risk screening programme by community pharmacists found that it was possible to provide near-patient cardiovascular